MEDDIC-MS Data Book

Medicaid Encounter Data Driven Improvement Core Measure Set

Vol. 1--2003 HMO Aggregate Performance Data Wisconsin Medicaid and BadgerCare Programs

Wisconsin Department of Health and Family Services
Division of Health Care Financing, Bureau of Managed Health Care Programs

December 2004

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Volume 1: 2003 HMO Aggregate Performance Data
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Results on Non-clinical Performance Measures included in the CAHPS® Medicaid/BadgerCare Enrollee Satisfaction Survey are reported separately in the "CAHPS® Medicaid/BadgerCare Enrollee Satisfaction Survey Executive Summary Report."

MEDDIC-MS Data Book, Vol. 1, 2003 HMO Aggregate Performance Data, Wisconsin Medicaid and BadgerCare Programs, State of Wisconsin, Department of Health and Family Services*,* December 2004.

Introduction and Background

MEDDIC-MS (Medicaid Encounter Data Driven Improvement Core Measure Set) is Wisconsin's set of standardized performance measures for Medicaid and BadgerCare (the State Children's Health Insurance Program, SCHIP) managed care. Use of MEDDIC-MS was approved by the Centers for Medicare and Medicaid Services (CMS) as part of its review of the state's quality improvement strategy in August 2003.

In October 2003, the Agency for Healthcare Research and Quality (AHRQ) recognized MEDDIC-MS for inclusion in the National Quality Measures Clearinghouse (NQMC®). To view the measure summaries on the NQMC, go to: http://www.qualitymeasures.ahrq.gov/resources/measureindex.aspx and scroll down to "State of Wisconsin."

MEDDIC-MS is a fully automated system, utilizing HMO encounter data and other State-controlled electronic data sources, without paper medical record review. This improves patient privacy protection, significantly reduces costs associated with data acquisition and eliminates potential data contamination caused by inaccurate patient-supplied history. Medical record review continues to be used for data validity audits, ambulatory quality of care audits, and cases where HMOs wish to augment encounter data and special audit functions.

The Department of Health and Family Services (DHFS) extracts data for each measure and calculates each HMO's performance on the measure through a third party data services vendor. This facilitates greater consistency, completeness and accuracy in calculation of the measures than having each HMO calculate and report its own rates.

MEDDIC-MS includes Targeted Performance Improvement Measure (TPIM) topics that have been in use in Wisconsin for a number of years, but the measures are designed to work in the automated encounter data environment. The *monitoring measures* included in MEDDIC-MS are consistent with a number of topics used in the past. They include utilization trending measures as well as clinical outcome measures.

The performance results on these measures for 2002 are available on the Wisconsin Medicaid Managed Care Website. To view these reports, please go to: http://www.dhfs.state.wi.us/medicaid7/reports_data/index.htm or http://www.dhfs.state.wi.us/medicaid7/providers/index.htm and scroll down to "Provider Quality Reports."

The data in this booklet presents program-wide performance rates for all HMOs combined on all MEDDIC-MS performance measures based on CY 2003 data.

Complete technical specifications for the MEDDIC-MS measures are available upon request. Contact: Gary R. Ilminen, RN at (608) 261-7839 or ILMINGR@DHFS.STATE.WI.US.

Care Analysis Projects

Since 2001, the Department has implemented an innovative program-wide proactive approach to performance improvement called Care Analysis Projects (CAP). Through CAP, enrollee-specific health care needs are identified and the data about those needs are shared with the enrollee's HMO. In this way, the Department seeks to assist in quality improvement by allowing HMOs and providers to focus outreach on individuals with unmet needs.

CAP focuses on several chronic conditions and on the provision of key preventive services. Chronic conditions included are congestive heart failure, asthma, and diabetes. Preventive health services include lead screening and prenatal risk assessment.

MEDDIC-MS and CAP work together. CAP provides data-driven targeted intervention and MEDDIC-MS allows accurate, rapid-cycle performance assessment.

HMO Performance Improvement Projects

Since the early 1990's the HMO contract has required HMOs to complete at least two performance improvement projects in each calendar year and submit reports about them to the Department annually. Analysis of those reports by the Department's quality improvement staff revealed that between CY 1997 and CY 2000, 73 percent of HMO interventions on topics of performance improvement projects resulted in some degree of improvement.

Other volumes in the MEDDIC-MS 2003 Data Book include:

MEDDIC-MS Data Book, Volume 2, 2003 HMO Performance Data Medicaid Program Data and BadgerCare Program Data Compared.

MEDDIC-MS Data Book, Volume 3, 2003 HMO-specific Performance Data, Wisconsin Medicaid and BadgerCare Programs.

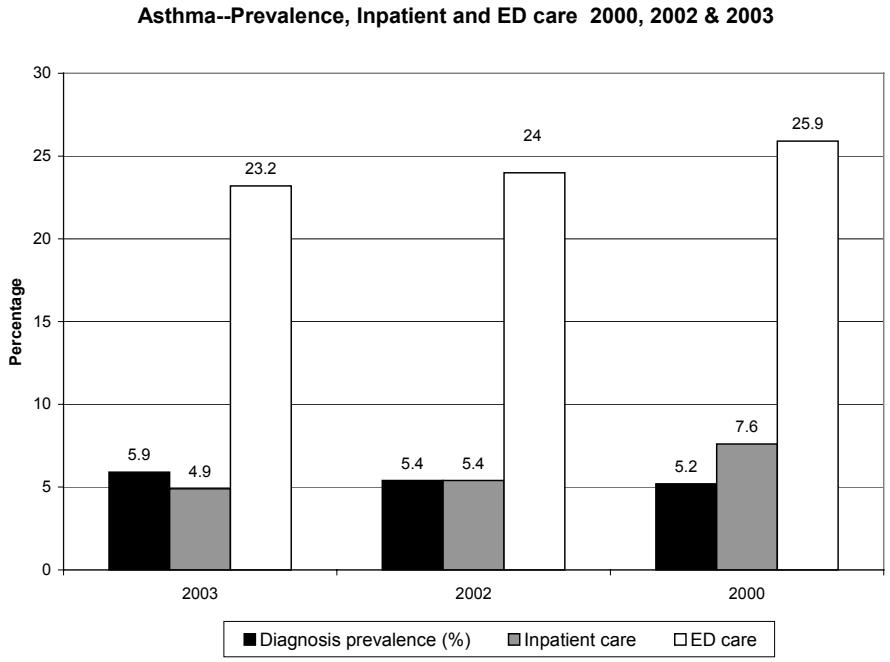
Results on Clinical Performance Measures

Asthma care

Monitoring measure

Asthma is a chronic respiratory condition affecting the lungs. People with asthma suffer episodes where airflow in and out of the lungs is reduced by constriction of the airways in the lungs and by excess mucous. Between 12 and 15 million Americans have asthma, including nearly 5 million children. The disease can have fatal complications.

Episodes of asthma can be reduced with effective management with appropriate medications and patient education. For these reasons, early diagnosis, patient/parent education and medical management are crucial to prevention of exacerbation and maintenance of good quality of life.



Prevalence--the percentage of enrollees with the diagnosis of asthma--increased slightly from 2000 to 2003. Despite the increasing prevalence of the disease, HMOs have shown progress in ambulatory care for this condition, with the utilization of both emergency department care and inpatient care declining in the same time period. Use of ED care for asthma decreased from 25.9 percent in 2000 to 23.2 percent in 2003; use of inpatient care for asthma declined from 7.6 percent in 2000 to 4.9 percent in 2003.

Progress may be the result of HMO disease management programs--9 of 13 HMOs responding to a 2004 survey of participating Medicaid/BadgerCare HMOs indicated they have asthma disease management programs in effect. In addition, 7 of 13 HMOs have conducted performance improvement projects on asthma care since 2000. Finally, the Department has operated a Care Analysis Project on asthma since 2001.

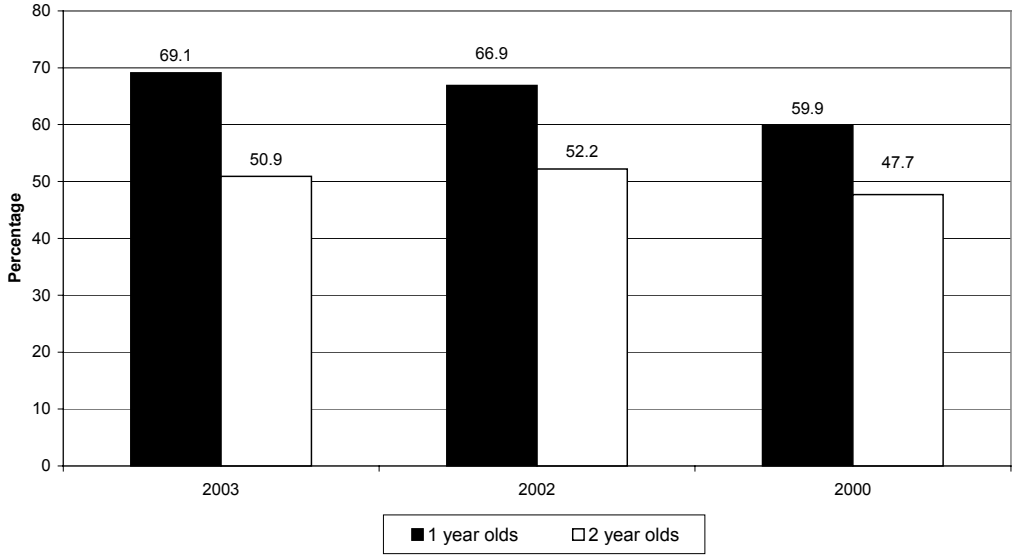
Blood lead toxicity screening

Targeted performance improvement measure

Children in Medicaid are considered to be at risk for exposure to sources of lead poisoning in their living environment. For this reason, provision of blood lead toxicity testing is required for children at age one and two years and up to age six if elevated levels or risk factors have been identified.

In the Wisconsin Medicaid & BadgerCare HMO program, blood lead toxicity screening at age one and two years is required under the contract and is a Targeted Performance Improvement Measure in the MEDDIC-MS performance measure system.

Blood Lead Toxicity Screening, 1 & 2 Year olds, 2003 Compared to 2002 and 2000



Blood lead toxicity screening rates improved between 2000 and 2003 for both one and two year old children. The screening rate for one-year-old children increased from 59.9 percent in 2000 to 69.1 percent in 2003. The screening rate for two-year-old children increased from 47.7 percent to 50.9 percent in the same period, although there was a slight decrease in the rate from 2002, which was 52.2 percent.

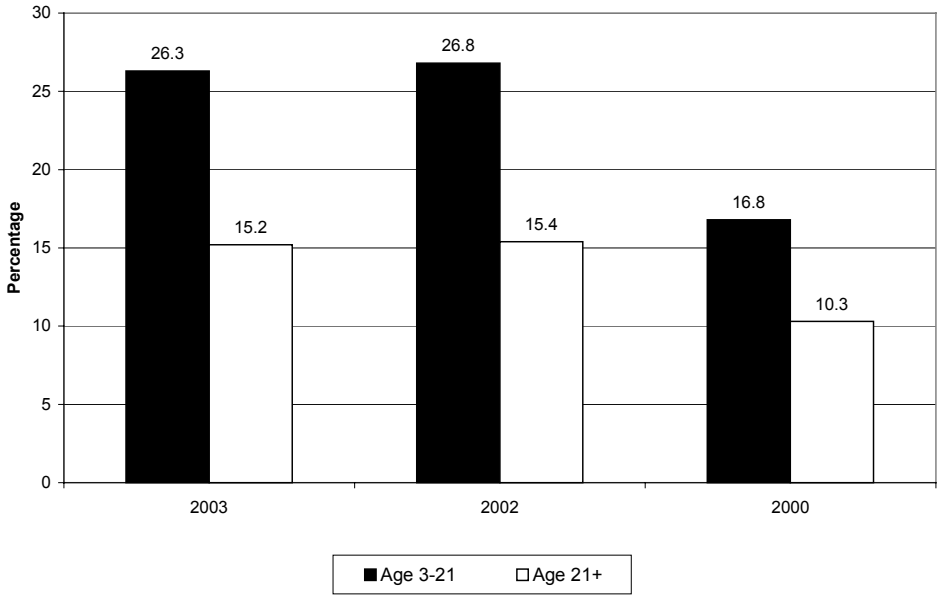
In 2001, the Department instituted the Care Analysis Project (CAP) on blood lead toxicity screening. Recipient-specific lead testing data is shared with the individual's HMO in an effort to assist HMOs with identification of children in need of lead screening. This facilitates outreach and follow-up for children who have not received screening. This effort may be a factor in the recent improvement in the lead screening rate trends.

In addition, 5 of 13 Medicaid/BadgerCare HMOs have conducted performance improvement projects on lead screening since 2000.

Dental (preventive) services

Targeted performance improvement measure

Dental (Preventive) Care, Age 3-21 and 21+ Years, Aggregate Data, 2003, 2002 and 2000 Compared



Preventive dental services include initial and comprehensive dental examinations, prophylaxis, topical application of fluoride and application of sealants.

Dental care can prevent development of dental caries, tooth loss, oral infections, abscesses and other problems. Preventive dental services are of particular value soon after the eruption of teeth for in young children. Teeth generally first erupt between age 6 and 28 months and emerge enough to benefit from preventive care between 1 and 3 years.

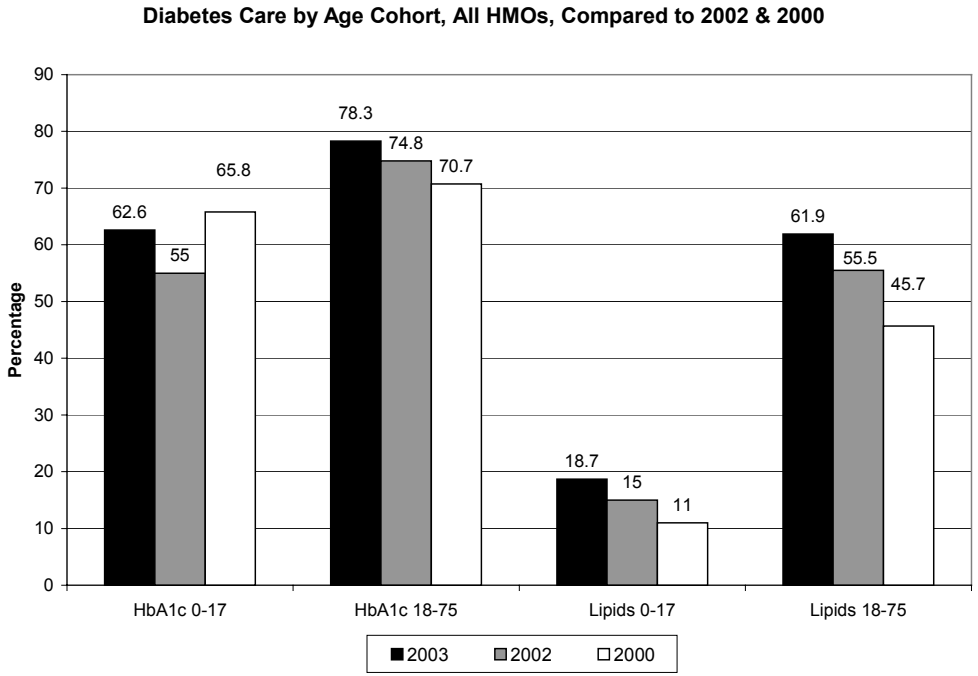
Three HMOs in the Milwaukee area of 13 participating in Medicaid/BadgerCare offer dental services. HMO enrollees in the rest of the state receive dental benefits on a fee-for-service basis; but about half of all HMO enrollees receive dental benefits through their HMO.

Access to dental services has been a challenge in the Medicaid program for quite some time, but has improved since 2000. Efforts on the part of the Medicaid/BadgerCare HMOs to perform outreach to enrollees and to improve their dental provider networks appear to have improved results on this dental service access indicator between 2000 and 2002; the rate remained nearly identical in both age cohorts between 2002 and 2003.

Despite the apparent improvement in access indicated by higher utilization for both age groups, the overall percentage of enrollees receiving preventive dental services remains relatively low, suggesting that dental care remains a performance improvement opportunity.

Diabetes care

Targeted performance improvement measure



Diabetes mellitus is a chronic condition that can have devastating effects including heart disease, kidney damage and blindness. With proper care, serious consequences can be reduced or prevented.

Two routine blood tests are important for appropriate diabetes management.

One test is the hemoglobin A1c (HbA1c), which is a blood test that indicates the level of blood sugar control over time. The other test is the lipid profile, which is a blood test that monitors the levels of "fats" (lipids) in the blood stream. Though these tests do not allow definitive assessment of quality of life for diabetic individuals nor of total quality of care for diabetes, they do allow assessment of key indicators of diabetic management. The chart reflects the percentage of HMO enrollees diagnosed with diabetes who received the tests. The percentages are reported by two age groups: birth (0) to age 17 years and 18 to 75 years of age.

Ambulatory care for diabetes has improved overall between 2000 and 2003. Lipid test rates increased from 45.7 percent for 18-75 year olds in 2000 to 61.9 percent in 2003. HbA1c test rates increased from 70.7 percent for 18-75 year olds in 2000 to 78.3 percent in 2003. The HbA1c rate for 0-17 years of age declined from 65.8 percent in 2000 to 55.0 percent in 2002, but has increased to 62.6 percent in 2003.

Seven HMOs have conducted performance improvement projects on diabetes care since 2000 and it has been a Care Analysis Project topic since 2001. In addition, 11 of 13 HMOs have disease management programs for diabetes.

EPSDT (HealthCheck) comprehensive well-child exams

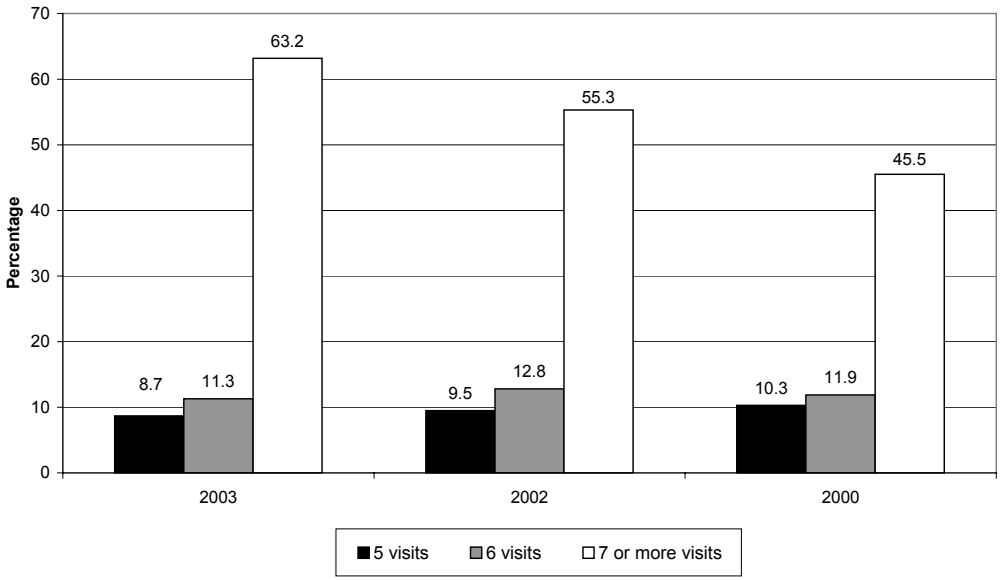
The federal mandate to state Medicaid programs includes provision of Early, Periodic Screening, Diagnosis and Treatment (EPSDT) services for children. Wisconsin's EPSDT services are called HealthCheck screens. HealthChecks include an unclothed physical exam, age appropriate immunizations, lab work, including blood lead toxicity tests, health and developmental history, vision and hearing tests, and oral assessment beginning at age 3.

Nine HealthCheck visits should be provided to each child by age two years. Significant improvement has occurred in the percentage of children receiving 7 or more HealthCheck exams by age two years. The rate has increased from 45.5 percent in 2000 to 63.2 percent in 2003. HealthCheck screens remain a quality priority.

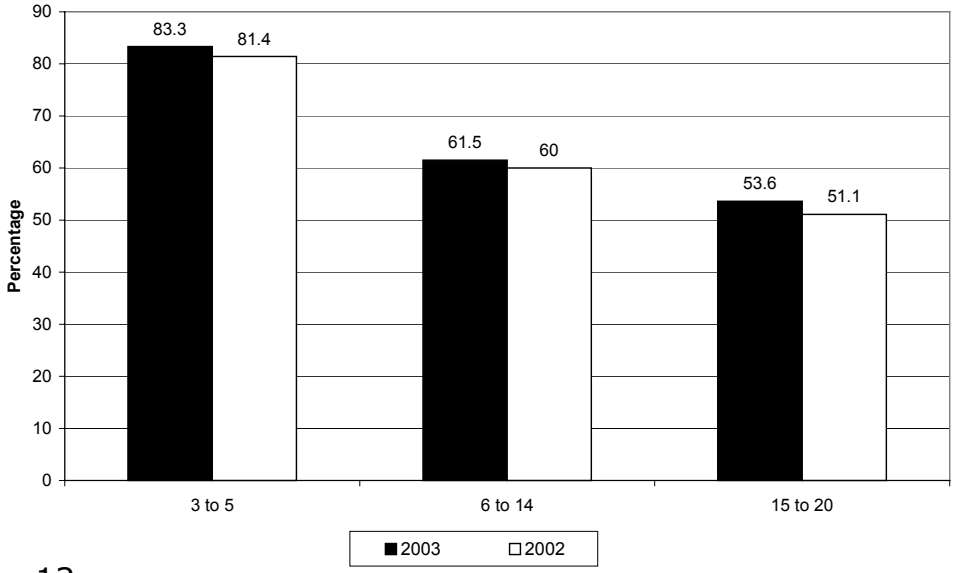
National data shows that older children receive EPSDT services less frequently. Wisconsin data exhibits a similar trend. However, the rates for children in each age cohort between age 3 and 20 years of age receiving at least 1 visit in the look-back period has increased slightly.

Ten of thirteen Medicaid/BadgerCare HMOs have conducted performance improvement projects on HealthCheck since 2000. Data for age group 3-20 years was not calculated in 2000.

HealthCheck (EPSDT) Examinations, Children Birth to Age 2 Years with 5, 6 or 7 Exams, All HMOs, 2003, 2002 and 2000 Compared



HealthCheck (EPSDT) Encounters, Ages 3-20, All HMOs, 2003 & 2002 Compared

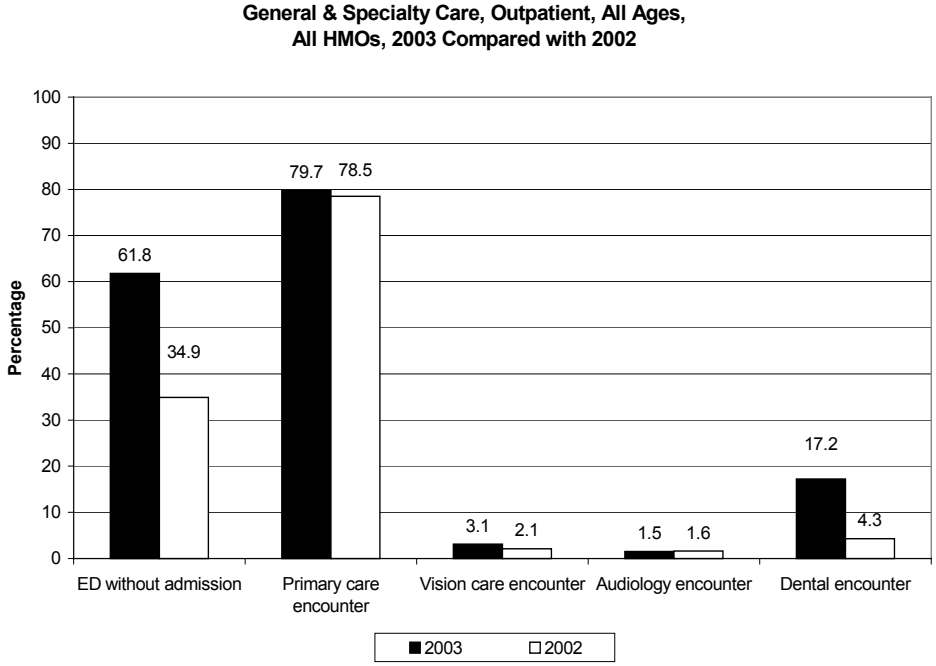


General and specialty care-outpatient

Monitoring measure

This measure assesses access to emergency care that does not result in subsequent hospitalization, access to primary care, vision care, audiology services and dental care. Access to these outpatient or ambulatory care services is essential for overall health maintenance and improvement.

The measure tracks what percentage of Medicaid and BadgerCare HMO enrollees had access to those services on at least one occasion during the look-back period. The chart displays the overall results for 2003, with comparative data for 2002.



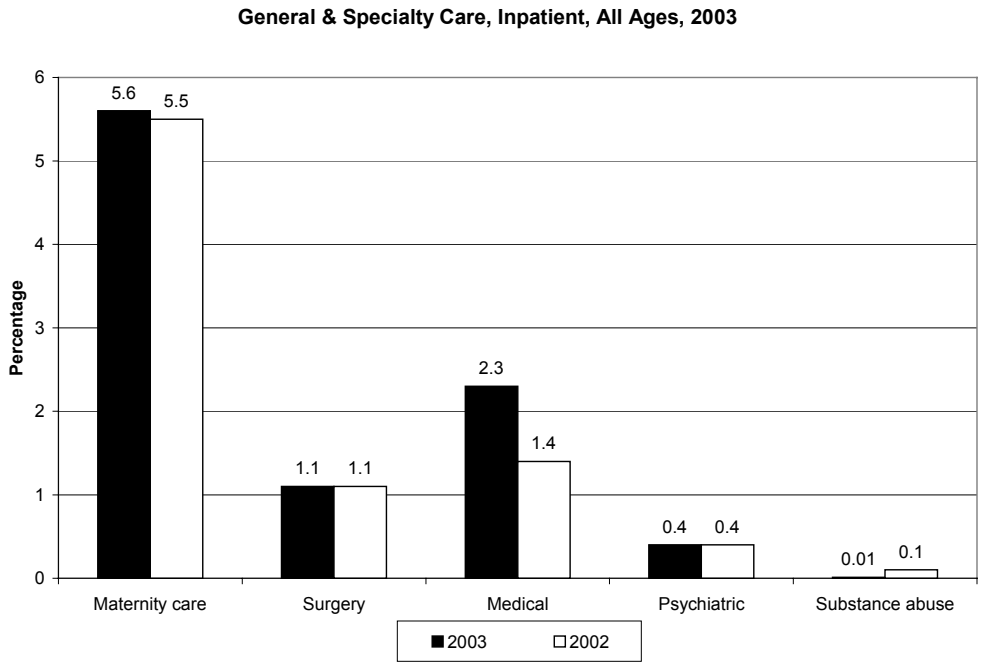
The measure reveals that nearly two-thirds of all HMO enrollees had at least one emergency department (ED) care encounter that did not result in subsequent hospitalization in 2003. This was a significant increase from 2002. High ED use may be caused by a number of factors, but the increase in this indicator is not a favorable trend. The DHFS has initiated a collaborative project with a variety of stakeholders to address increasing ED use.

Primary care access for enrollees of all ages was good, with nearly 8 out of every 10 HMO enrollees having at least one primary care encounter in the look-back period for both 2003 and 2002. Access to vision and hearing services remained stable.

Dental encounters appear small in proportion also, but only 3 participating HMOs provide dental care under their contract with the Department. Access and utilization of general dental services improved significantly from 2002 to 2003, but remains a performance improvement opportunity. See also "Dental (preventive) care" on page 10 for further information.

General and specialty care-inpatient

Monitoring measure



Some conditions may require care or services that cannot be provided on an ambulatory or outpatient basis. Those conditions may require hospitalization, referred to as inpatient care.

Inpatient care may be necessary for many different conditions. For the purposes of the Medicaid/BadgerCare HMO performance monitoring program, five general categories of care are used: maternity, surgery, medical, psychiatric and substance abuse.

This monitoring measure is useful as a tool in assessing access and utilization of inpatient care services. By itself, this measure is not an all-inclusive indicator of sufficiency of access to services, or of appropriateness of care. However, when used in conjunction with other data such as satisfaction, grievance and appeal data, outpatient care data and other measures, it provides a reasonable basis for assessment of overall service delivery.

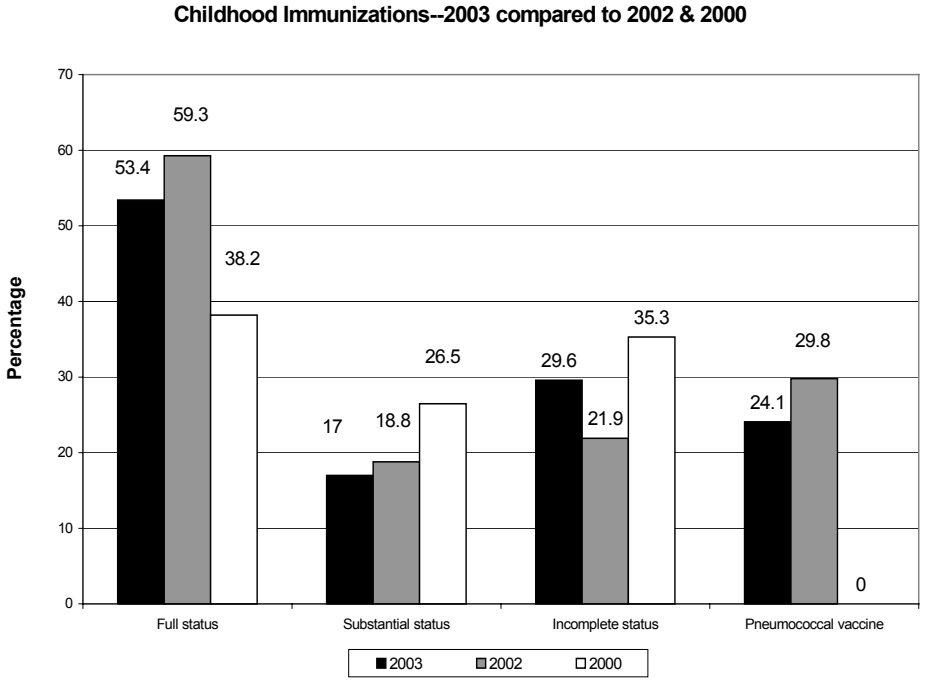
Maternity care, surgical care and psychiatric care rates were nearly unchanged from 2002 to 2003. Use of inpatient medical care increased from 1.4 percent to 2.3 percent, while inpatient substance abuse care decreased.

Immunizations for children

Targeted performance improvement measure

Achieving "full" immunization status as defined by the Centers for Disease Control and Prevention (CDC) can protect young children from ten potentially serious infectious diseases. Immunization is believed to be one of the safest and most effective health interventions available.

This measure assesses the percentage of children enrolled in Medicaid/BadgerCare HMOs who have achieved full immunization status, substantial immunization status and who have incomplete immunization status. The rate of administration of 4 doses of the multivalent pneumococcal vaccine is included as a monitoring measure. Substantial status refers to children who have received most but not all of the doses of certain vaccines given in multi-dose series believed necessary to confer substantial immunity.



Overall, the rate of full immunization status decreased 5.9 percent from 2002 to 2003, though the overall trend in full immunization increased 15.2 percent from 2000 to 2003. The 2002 rates have been adjusted for this report from what was previously reported to compensate for a data program change made between 2002 and 2003. The adjustment preserves comparability across all three years.

Vaccine shortages affecting several antigens occurred in 2002 and some shortages persisted into 2003. This period coincides with the time when many children in the age range included in this performance measure were due to receive their immunizations. Consequently, it is likely that in many instances, clinics were unable to provide the number of immunizations required in order to reach full immunization status.

Vaccine shortages may also have affected the rate of pneumococcal vaccination. The rate for children receiving 4 doses decreasing by 5.7 percent between 2002 and 2003. A rate for this antigen was not calculated for 2000.

Mammography (screening) and malignancy detection

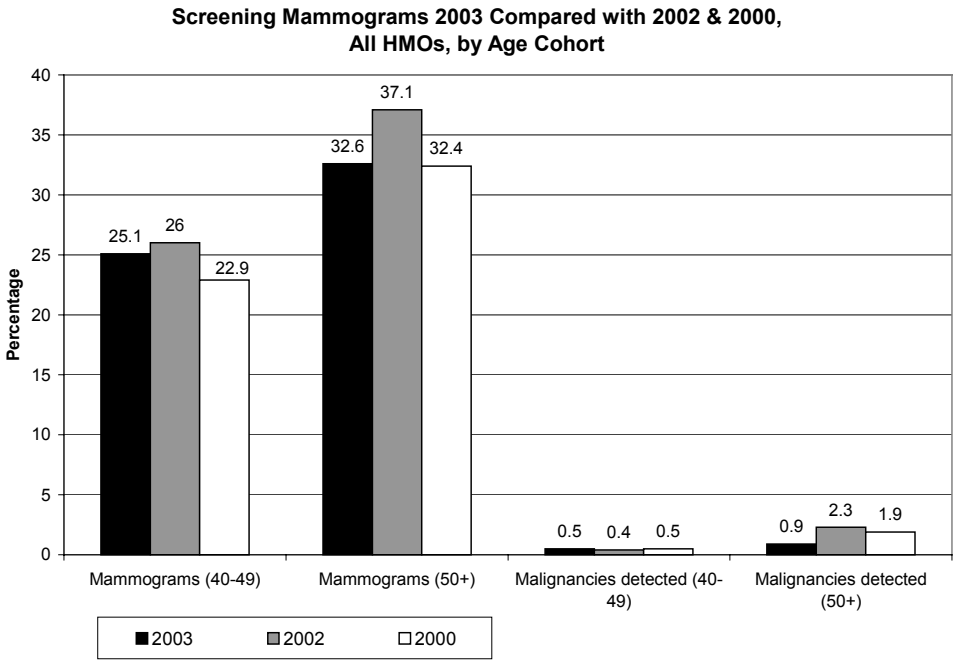
Monitoring measure

Early detection of breast cancer improves outcomes of treatment and long-term survival.

Mammography is recognized as a highly effective method for early detection of breast cancer.

The American Cancer Society and the National Cancer Institute each recommend that women over age 40 have regular screening mammograms.

Though only a very small percentage of enrollees in Medicaid/BadgerCare are women over age 40, facilitating and tracking the provision of screening mammography is important because of the benefits of early detection and treatment.



The percentage of women in both age groups in the measure who received screening mammograms decreased somewhat from 2002, but the rates remained slightly higher than in 2000.

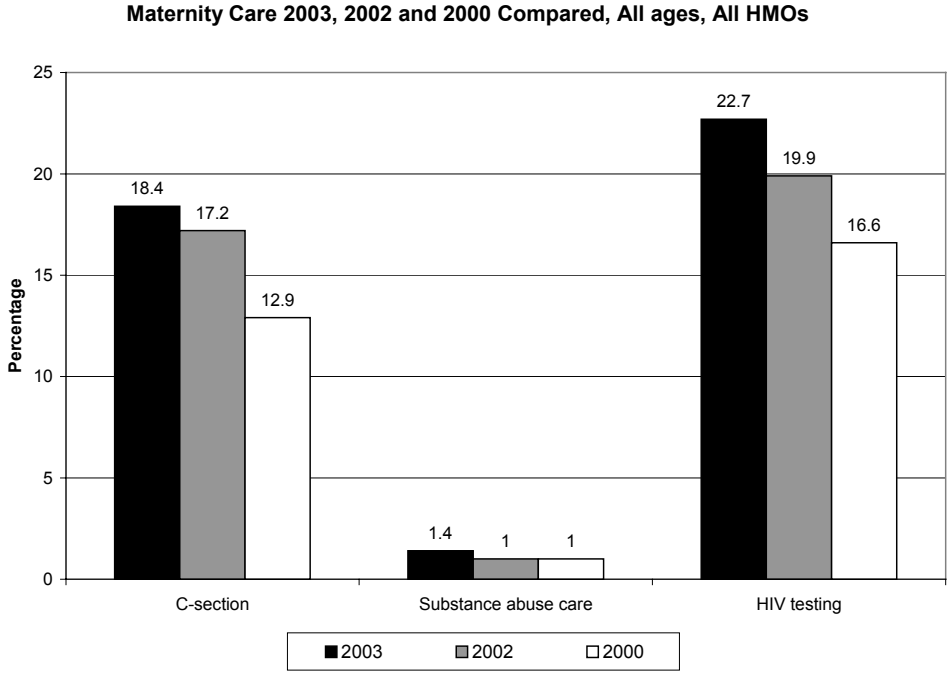
The outcome measure for this service, detection of breast malignancies, remained stable in the 40-49 year age group at 0.5 percent. The malignancy detection rate in the 50+ age group decreased from 2.3 percent in 2002 to 0.9 percent in 2003.

Maternity care

Monitoring measure

Cesarean section (C-section) childbirth may be the safest form of delivery in certain circumstances. However, since C-sections pose risks of their own, the procedure should be used only when it is truly necessary. For these reasons, and the prevalence of women of child-bearing age in Medicaid/BadgerCare, tracking the use of the procedure is of particular importance.

Provision of other health care services in the perinatal period may be of very high importance to the health of both mother and child. Two services that are monitored in the MEDDIC-MS measure set are provision of substance abuse services and voluntary HIV screening tests.



A possible performance improvement opportunity exists in the area of maternity care, particularly births by Cesarean section. The rate of births by C-section increased from 12.9 percent in 2000 to 17.2 percent in 2002 and increased further in 2003, rising to 18.4 percent of live births. There has also been a national trend toward increased use of C-sections. According recent data from the Centers for Disease Control and Prevention, the national rate has increased from 20.8 percent in 1995 to 25.3 percent of all births in 2001.[1]

Provision of substance abuse care in the perinatal period remained stable at about 1.0 percent, increasing only slightly to 1.4 percent in 2003. Provision of HIV screening increased from 16.6 percent in 2000 to 22.7 in 2003.

[1] Kozak LJ, Owings MF, Hall MJ. National Hospital Discharge Survey: 2001 annual summary with detailed diagnosis and procedure data. National Center for Health Statistics. Vital Health Stat 13(156). 2004.

Mental health/substance abuse (MH/SA) follow-up care within 7 and 30 days of inpatient discharge

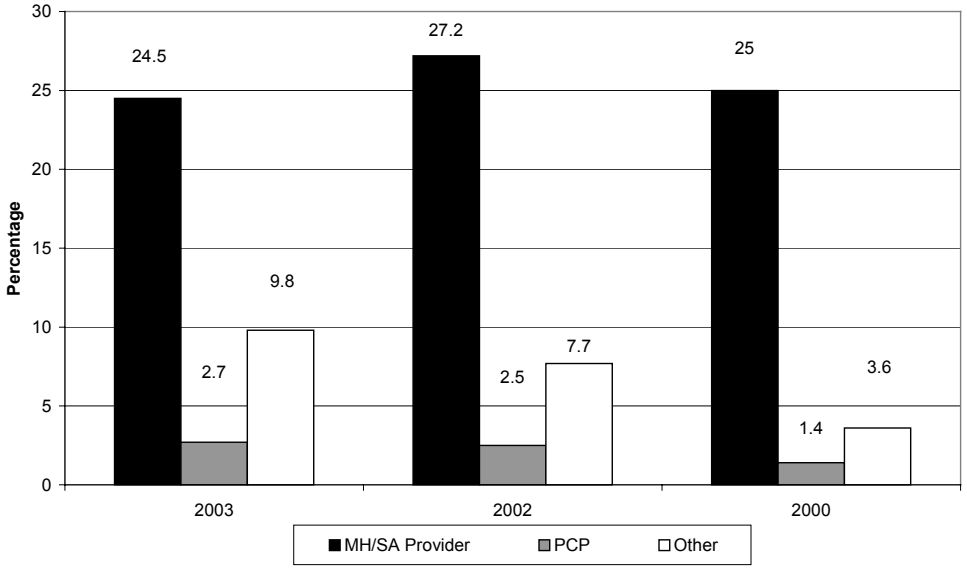
Targeted Performance Improvement Measure

Research has shown that follow-up care on an outpatient basis for individuals who have had inpatient care for mental illness or substance abuse is effective in reducing readmission to the inpatient setting for the same diagnosis.[2]

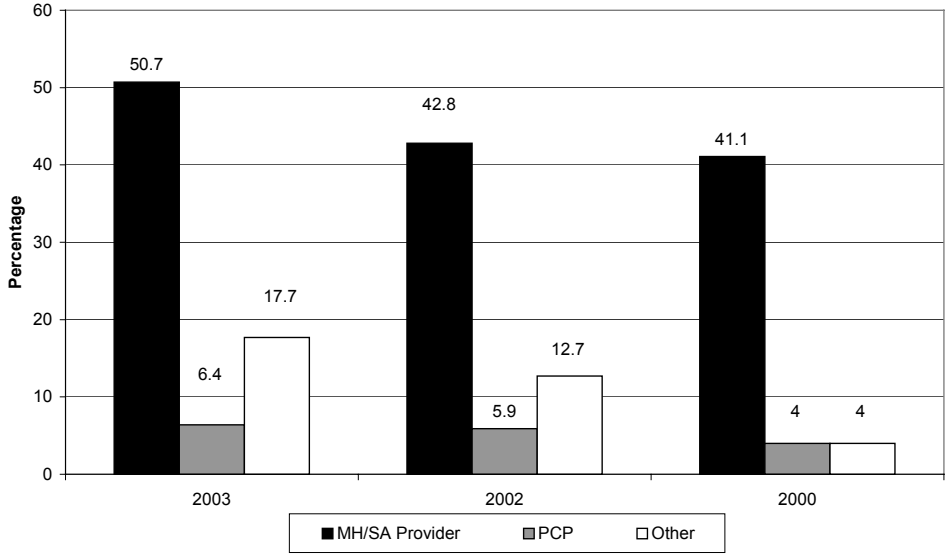
This measure evaluates provision of outpatient follow-up care by both specialty care providers and primary care providers (PCP) within 7 days of discharge and within 30 days of discharge from an inpatient mental health or substance abuse stay. For instances when appropriate service codes appear on encounter records but the provider type is not specified, the services are included in the category "other" to avoid underreporting.

Overall, access to follow-up care, as indicated by utilization data, by all providers has generally increased from 2000 to 2003. Follow-up care by specialists within 7 days of discharge has stayed about the same from 2000 to 2003.

Mental Health & Substance Abuse Ambulatory Care within 7 Days after Inpatient Stay by Provider Type, Age 6+ years, 2000-2003



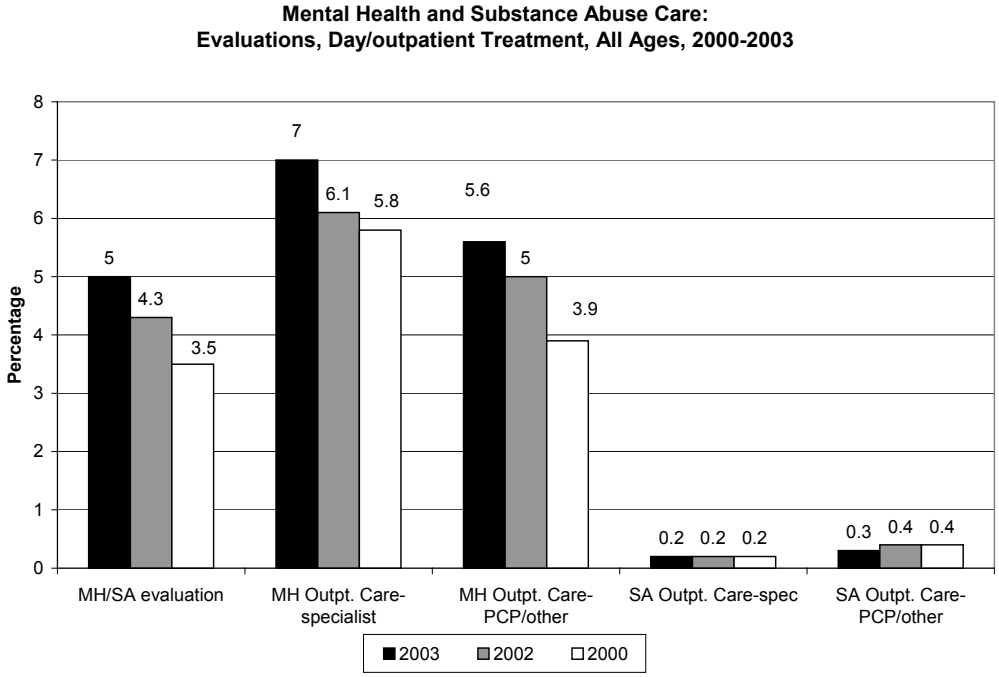
Mental Health & Substance Abuse Ambulatory Care within 30 Days after Inpatient Stay by Provider Type, Age 6+ years, 2000-2003



[2] *Evaluation and the Health Professions, Special Edition, State Medicaid Quality Programs*, "Outpatient Utilization Patterns and Quality Outcomes after First Acute Episode of Mental Health Hospitalization," Delmarva Foundation, December 2000.

Mental health/substance abuse-evaluations and outpatient care

Monitoring Measure



The first step in access to mental health and substance abuse (MH/SA) services is often an evaluation by practitioner who specializes in those areas. The possibility that HMOs inappropriately restrict access to MH/SA evaluation and treatment services is a potential concern in the Medicaid/BadgerCare program. Monitoring the rate of evaluation and treatment services is useful to detect access trends.

Many mental health and substance abuse conditions can be successfully treated on a day treatment or outpatient basis. In addition, most people prefer such treatment to inpatient care, whenever possible. Thus, access to day and outpatient treatment services is both preferred by enrollees and useful to reduce the need for inpatient care.

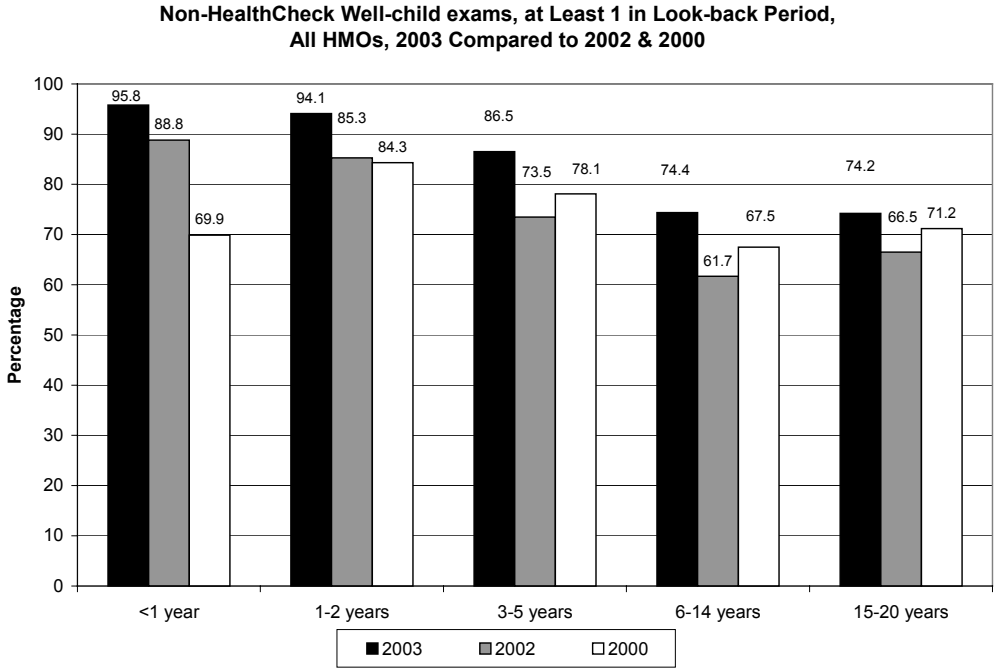
This measure tracks the provision of these services by provider type in order to gain insight into HMO network adequacy. Care by a specialist may be preferable or essential in some instances, however, due to a statewide scarcity of specialists, it may be necessary for primary care providers or even physician extenders to provide services in some cases. This is often appropriate and may be the consumer's choice due to location and trust in the provider.

Performance measure data indicates that access to mental health and substance abuse evaluations has increased from 3.5 percent in 2000 to 5.0 percent in 2003. Access to outpatient mental health care by both specialist and primary care providers increased in the period. Access to outpatient substance abuse care from specialist and primary care providers remained unchanged from 2000 to 2003.

Non-HealthCheck well-child exams

Monitoring measure

Non-HealthCheck well-child visits are primary care visits that may be too limited in scope to qualify as "HealthCheck visits," but do result in delivery of some preventive or other health services. A common example of such visits is a postnatal visit for a new mother that is timed to coincide with the due date for immunizations for the child, where the immunizations are given, but may not involve the full HealthCheck exam.



The positive health and economic effects of well-child services, particularly in early childhood have been demonstrated in a recent study.[3]

The study found that states with the highest rates of provision of well-child visits had the lowest rates of preventable hospitalizations for those children. Conversely, states with the lowest rates of well-child care had the highest rates of preventable hospitalizations.

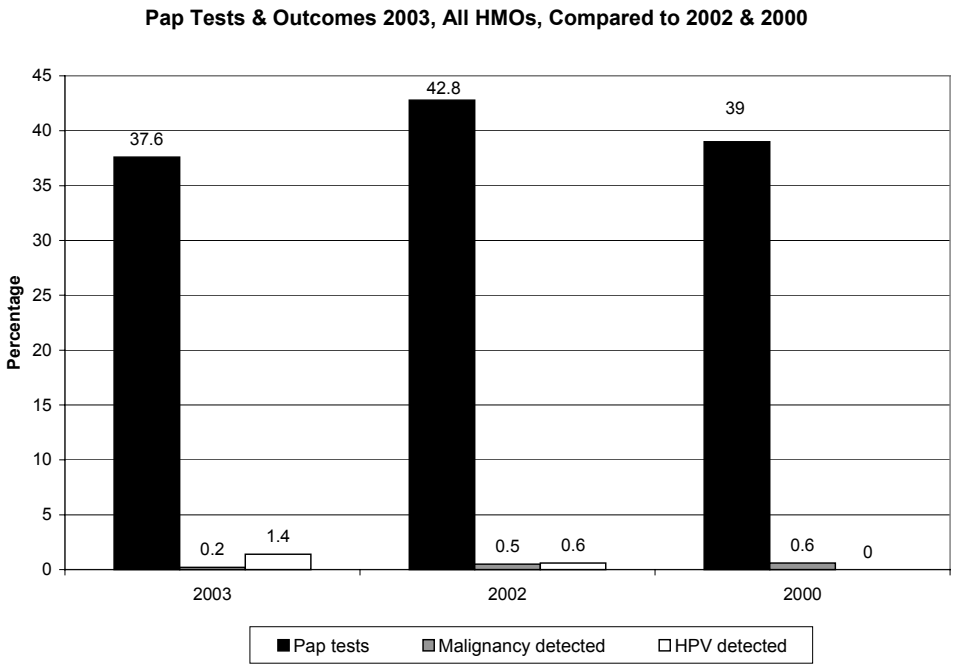
The authors of the study concluded that the "association between preventive care and a reduction in avoidable hospitalizations was robust and was consistent across the states and racial and ethnic groups."

Data for children with at least one visit in the look-back period shows significantly improved access among children <1 year of age since 2000. That rate increased by 25.9 percent. Visit rates in all other age groups have also increased since 2000, though not as significantly as in the one-year-old and under cohort.

[3] *Effectiveness of compliance with pediatric preventive care guidelines among Medicaid beneficiaries*. Hakim RB, Bye BV. July 2001. PEDIATRICS, Vol. 108, No.1:90-97.

Pap tests-cervical cancer screening

Monitoring measure



The majority of Medicaid/BadgerCare enrollees are females and women of child-bearing age make up a significant number of HMO enrollees. Consequently, women's health services are of particular significance to the Medicaid/BadgerCare HMO program.

According to the Centers for Disease Control (CDC), cervical cancer remains a leading preventable cause of death among women. Cervical cancer is diagnosed in approximately 15,000 women in the United States each year. Early detection is relatively easy and is the key to a high probability of survival. The most common method for early detection is called the "Pap test."

According to the CDC, Human Papillomavirus (HPV) infection is a causal factor in more than 90 percent of cervical cancers. This measure assesses the detection rates for malignancy and HPV infection.

The Pap test is generally performed every three years, beginning when the woman becomes sexually active or by age 18 years. Thus, the Pap test is not required annually, and the performance measure is designed to take this into account. The age group for this measure was changed from 19-65 years in 2000 to 18-65 in 2002.

Provision of cervical cancer screening tests (Pap tests) increased from 39 percent to 42.8 percent for women age 18-65 years between 2000 and 2002, but declined to 37.6 percent in 2003. Outcome measure results, the rate of detection of malignancy, for this service decreased slightly to 0.2 percent in 2003 from 0.5 percent in 2002 and 0.6 percent in 2000. The HPV detection rate increased slightly from 0.6 percent in 2002 to 1.4 percent in 2003. One HMO has conducted a performance improvement project on increasing Pap test rates since 2000.

Analysis of performance trends, quality improvement opportunities and strategic implications

Calendar year 2003 data on clinical performance indicators revealed further improvement in overall HMO program performance. For those measures where data can be trended from 2000 to 2003, most show that the quality improvement strategy to "ramp up" performance over time appears to be having a positive effect.

Summary of trends on selected measures from 2000 to 2003:

- ***Asthma care:*** Prevalence of asthma remained unchanged, but the need for emergency department services for asthma declined from 25.9 to 23.2 percent and the need for inpatient care declined from 7.6 to 4.9 percent.
- ***Blood lead toxicity screening:*** rates improved--increasing from 59.9 to 69.1 percent for 1 year olds and from 47.7 percent to 50.9 percent for 2 year olds.
- ***Childhood immunizations:*** rate for children with full immunization status[4] increased from 38.2 to 52.8 percent. However, widespread vaccine shortages in 2002 caused this rate to decrease from 2002 to 2003.
- ***Diabetes care:*** hemoglobin A1c (HbA1c) testing rate improved from 70.7 to 78.3 percent and lipid profile testing rate improved from 45.7 to 61.9 percent for adult diabetics.
- ***EPSDT (HealthCheck) well-child exams:*** rate for children age 2 years and younger receiving 7 or more exams improved from 45.5 to 63.2 percent. Rates for older children receiving at least one exam increased in each age cohort, though only incrementally.
- ***General & specialty outpatient care:*** The rate for ED encounters without subsequent admission increased from 34.9 percent in 2002 to 61.8 percent in 2003. Primary care encounter rates remained stable at just under 80 percent. Vision and audiology utilization rates remained about the same. General dental care increased from 4.3 to 17.2 percent.
- ***General & specialty inpatient care:*** All rates for inpatient services remained nearly unchanged.
- ***Mammography (breast cancer detection for women):*** rate increased from 22.9 to 26 percent for women age 40-49 years in 2002, but declined slightly to 25.1 percent in 2003. For women age 50+ years of age the rate increased from 32.4 to 37.1 percent in 2002, but decreased to 32.6 percent in 2003. Malignancy detection remained stable during the period.

[4] Based on Centers for Disease Control (CDC) Advisory Committee on Immunization Practices (ACIP) recommendations.

- ***Maternity care:*** C-section rate increased from 12.9 in 2000 to 18.4 in 2003. Substance abuse treatment in the perinatal period remained stable at about 1 percent. Voluntary HIV testing rate increased from 16.6 to 22.7 percent.
- ***MH/SA follow-up care:*** Follow-up care within 7 days by specialist remained about the same from 2000 to 2003, about 25 percent; within 30 days it increased from 41 to 50.7 percent. Follow-up by PCPs in both time frames trended up slightly, but follow-up by "other" or "unspecified" providers increased in the 7 day indicator from 3.6 to 9.8 percent and in the 30 day indicator from 4 to 17.7 percent.
- ***MH/SA evaluations and outpatient care:*** Evaluations increased from 3.5 to 5 percent from 2000 to 2003. MH day treatment by specialists increased from 5.8 to 7 percent; by PCPs/others from 3.9 to 5.6 percent. Substance abuse outpatient care by all provider types remained stable from 2000 to 2003.
- ***Pap tests (cervical cancer detection for women):*** This rate decreased from 39 to 37.6 percent, after having improved to 42.8 percent in 2002. Malignancy and HPV detection rates were stable during the period.
- ***Preventive dental care services:*** This rate showed significant improvement, increasing from 16.8 to 26.3 percent for children age 3-21 years and from 10.3 to 15.2 percent for adults 21 years of age and older.
- ***Well-child exams--(non-HealthCheck):*** This rate increased for children birth to age 1 year from 69.9 to 95.8 percent. Rates of provision of this service increased in all other age cohorts up to age 21 years as well.

Combined efforts appear to pay off

Results in clinical areas where combined efforts by the DHFS and participating Medicaid/BadgerCare HMOs have been brought to bear appear to have improved.

For example, emergency department and inpatient care utilization for asthma declined from 2000 to 2003, even though disease prevalence was unchanged (see page 8). The DHFS has operated a Care Analysis Project (CAP) on asthma since 2001, 9 of 13 HMOs responding to a 2004 survey indicated that the HMO has a disease management program for asthma and 7 of 13 HMOs have conducted performance improvement projects on the subject since 2000.

In addition, improvements in provision of diabetes management services occurred between 2000 and 2003 (see page 11). As with asthma, diabetes has been included in the Care Analysis Project since 2001, and has been the subject of seven HMOs' performance improvement projects since 2000. In addition, 11 of 13 HMOs have disease management programs for diabetes. These combined approaches appear to be effective strategies in improving quality of care even in areas of care that have been historically difficult to influence.

These combined efforts have contributed to better identification, outreach and ambulatory care for individuals with asthma and diabetes, though the exact contribution of each approach cannot be quantified.

Strategic implications

These findings suggest several strategy options for further quality performance improvement program-wide. They include:

- Broaden the Care Analysis Project to include additional topics.
- Add a method for systematic goal-setting for MEDDIC-MS Targeted Performance Improvement Measures. This is currently in its implementation phase.
- Consider incentives for all HMOs to develop disease management programs for chronic conditions.
- Consider options to increase the number and effectiveness of HMO performance improvement projects.
- Assess the effectiveness of the Department's current strategy for early identification of enrollees with special health care needs.
- Consider incentives to improve access to primary care. This is being addressed with an effort to develop a primary care access incentive program.

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